

## Correspondence

EDITED BY TOM FAHY

**Contents** ■ Costing community care ■ Impact on caregivers of the symptoms of dementia ■ Seasonal variation in bipolar disorder ■ Terminology of learning disability ■ Valproate and neuroleptic medication ■ Genetic polymorphism and drug-induced movement disorders ■ Demography and age at onset of schizophrenia ■ Working on the interface between primary and secondary care

### Costing community care

**Sir:** We strongly agree with the comment by Stanley & Macmillan (1996) made with reference to our article entitled 'The cost of comprehensive care of people with schizophrenia living in the community' (Salize & Rössler, 1996), that with cost studies in community health care only comparisons of like with like can gain full validity.

The aim of our study, however, was not to compare the community care cost of dehospitalised old long-stay patients with the costs these patients would have caused if they had been in full hospital care, as Stanley & Macmillan believe. Of course, the total community care costs of such a cohort would have been greater than those of 'new' long-stay patients, cared for in community-based mental health care since the onset of illness.

Against the assumption of Stanley & Macmillan our calculations do include costs for housing and food for all those patients of our cohort who had been cared for in residential care. Eighteen patients (27%) were living in sheltered homes for the mentally ill during the study period. The accommodation and food costs of the remaining patients were not taken into account as we only wanted to identify and calculate the direct care cost covered by the mental health care system and not the societal cost of care. If we were to add the average social welfare payment received by chronically mentally ill persons in Germany not in residential care, amounting to US\$ 330 per month, to our calculations for those patients of our cohort not accommodated in sheltered homes, the average cost of care for our total cohort would rise to \$21,257. This is only slightly higher than the figure we presented in our article (\$18,377) and still represents only 49.4% of the cost of a permanent stay in a state mental hospital.

Stanley & Macmillan point out that 'old' long-stay patients need sheltered accommodation to a much greater extent than the patients of our cohort. Our 18 patients cared

for in sheltered homes had a mean cost of \$36,452 per year for their comprehensive mental health care (including residential care, readmissions to psychiatric wards, crisis interventions, out-patient attendances, occupational therapy, drugs etc.). This is still only 84.7% of the lowest rate of an uninterrupted 12-month stay in a state mental hospital in Germany. Even when considering that dehospitalised 'old' long-stay patients probably would have more frequent or longer (and more expensive) readmissions, community-based mental health care in Germany seems to be the less costly alternative for these patients as well. All possible scenarios, based on empirical cost data from our study, underline that community-based mental health care is the more inexpensive option.

**Salize, H. J. & Rössler, W. (1996)** The cost of comprehensive care of people with schizophrenia living in the community. A cost evaluation from a German catchment area. *British Journal of Psychiatry*, **169**, 42-48

**Stanley, A. K. & Macmillan, J. F. (1996)** Costing community care (letter). *British Journal of Psychiatry*, **169**, 670.

**H. J. Salize** Central Institute of Mental Health, Mannheim, Germany

**W. Rössler** Psychiatric University Hospital, Zürich, Switzerland

### Impact on caregivers of the symptoms of dementia

**Sir:** Donaldson *et al* (1997) add welcome clarity to the difficult literature concerning the impact on caregivers of the symptoms of dementia. However, some additional points should be made.

First, despite reliance on the General Health Questionnaire in many studies of caregiver psychopathology, the validity of this instrument for assessing chronic morbidity is put in doubt by the inclusion of 'no more than usual' responses, which may indicate long-standing symptoms rather than their absence.

Second, the profound methodological difficulties involved in disentangling the relationship between patient behaviour and the caregiver's perception of it are inadequately addressed by even the most advanced instruments, which rely solely on reports by the caregiver and have not been validated against observational assessment using caregiver-blind video-recording.

Third, the authors fail to mention the importance of feelings of 'entrapment' in mediating between the symptoms of dementia and distress in caregivers. Impaired activities of daily living and the non-cognitive features of dementia generate a large caring commitment and consequently the feeling of being 'trapped', but when combined with lack of gratifying feedback from the patient (perhaps due to apathy or irritability, a poor pre-morbid relationship, lack of respite etc.), an accompanying desire to 'escape' is created. A thwarted wish or need to escape is highly depressogenic in animal models and is likely to be so for human carers (Gilbert, 1992).

**Donaldson, C., Tarrier, N. & Burns, A. (1997)** The impact of the symptoms of dementia on caregivers. *British Journal of Psychiatry*, **170**, 62-68

**Gilbert, P. (1992)** *Depression: The Evolution of Powerlessness*. Hove: Lawrence Erlbaum.

**S. Thacker** Mapleton Day Hospital, Derby City General Hospital, Uttoxeter Road, Derby DE22 3NE

**P. Gilbert** Mental Health Research Unit, Kingsway Hospital, Derby DE22 3LZ

### Seasonal variation in bipolar disorder

**Sir:** Partonen & Lönnqvist (1996) report no seasonal variation in bipolar disorder, except for a small group of autumnal depressions. They also point to the significant peak for manic and depressive admissions during the week after the autumnal equinox, thus bringing up the importance of a more precise definition of seasons (normally considered as three calendar months).

Irrespective of precise beginning and end points, the season as conventionally defined may not be the most suitable unit for testing psychiatric hypotheses. As the photoperiod increases progressively during winter and spring, and decreases during summer and autumn, it would be more rational to consider semesters rather than seasons. Even better would be an approach that considers each period of three months around solstices